April 21, 2015

House Insurance Committee Members:

Thank you for the opportunity to publicly comment on the Substitute for Senate Bill 248, proposing legislative changes to Michigan's Auto No-Fault Insurance.

I would like to comment as a physician, an experienced Physical Medicine & Rehabilitation specialist providing medical care for catastrophically-injured individuals with traumatic brain injuries and spinal cord injuries, as well as being an experienced Medical Administrator and a concerned citizen wishing to act as a steward concerned with the state's finances and the Health Status of its communities.

Briefly, I have been a practicing physician in the State of Michigan for 34 years. My focus has been on the treatment of catastrophically-injured individuals with traumatic brain injuries and spinal cord injuries and the development and supervision of inpatient rehabilitation programs and post-acute rehabilitation programs that are cost-effective, subject to rigorous utilization review, and are CARF (Commission on Accreditation of Rehabilitation Facilities) accredited.

I would like to acknowledge the current Michigan No-Fault Insurance Act of 1973. This act established lifetime coverage for reasonable and necessary expenses and accommodations for the patient's care, recovery, and rehabilitation. This outstanding vision of Republican Governor William Milliken was a brilliant piece of legislation that assured that these services would be provided through the private sector and not burden the public sector.

We recognize that you, like us, share the concept, "one should never attempt to do harm to others, but should always guard against the harm that might be done to others." When we are discussing catastrophic injuries, we are talking about some of our most vulnerable citizens.

Many of us in the audience today, perhaps like many of you, come from backgrounds of being CEOs, managers or medical directors. When we need to solve a problem, we use a performance improvement or quality initiative model.
We define and measure the problem.
We test the hypothesis.
We propose a strategy to resolve it.
We are asking our legislature to do the same.

There have been concerns raised about Auto No-Fault in terms of affordability, sustainability and fraud. However, there has been no real analysis of affordability and sustainability.

Let's get fraud out of the way first. Fraud is already prohibited by law. Insurance companies already have fraud divisions. They hire private investigators and videotape patients. I have seen these videos and when there is fraud, of course, I share that with the insurance company.

Therefore, why set up another entity and increase costs through increase Registration fees.
Is it simply to add the appropriations piece to the Bill. I supposed a benefit would be if it was determined to be fraud when an insurance company denies or delays a claim and patients go without services. Most fraud relates to theft and collision. Will all these options be included?

Catastrophic injuries, such as traumatic brain injury and spinal cord injuries, are defined that way because they are, indeed, catastrophic in terms of the severity of the injury, the trajectory of a person's life, the impact on their families and communities, and the costs associated with them. In many cases these injuries are "a life sentence." Thus, rehabilitation support efforts do not end after short periods of time. I will discuss this further later.

Currently, insurance companies selling no-fault insurance in Michigan have a "stop-loss" at $530,000 per case. The Michigan Catastrophic Claims Association (MCCA) acts as a reinsurer to protect the no-fault carriers for expenses greater than $530,000. The MCCA covers the remainder of the lifetime benefit.

I attached an article from Crain's Detroit from 3/29/11 relating to this topic. Michigan no-fault auto insurance carriers are not "an endangered species." It is my understanding that their current profit is in the range of 18-22%. They spend billions of dollars on advertising and sponsoring sporting events. By contrast, in the Crain's article, the Michigan Health and Hospital Association stated that average hospital profit margins on patient care services are "below zero." Nationally, hospital profit margins range from clear losses to a maximum of 5% profit. In Michigan, a hospital is doing well if the profit is 2-4%.

Insurance companies have ample recourse to assure that they are paying only for reasonable and necessary expenses. They can ask the prescribers for clarification. They can require letters of medical necessity for products and services. They have the right to obtain Independent Medical Evaluations from other physicians to help them clarify the case or an expense. They can hire nurse case managers to assist them. They already utilize Bill and Review Units to assess expenses. They often only pay to providers already what they consider a reasonable and customary amount. They have the ability to issue denials until information is clarified to their satisfaction. They also have the ability to request judicial reviews.

Discussions of affordability focus on decreasing reimbursement to providers or cutting benefits, with no consideration of insurance company profits.

The Bill states that Insurance company rates shall not be excessive, inadequate or unfairly discriminatory. Excessive was described as the rate being unreasonably high for the insurance coverage provided. If we are talking about affordability, then, by definition, the rates may be too high. On the other hand, the coverage being provided is exemplary. Clearly to solve this conundrum, you and we need information on Insurance company profitability and rate-making structure.

Should we assume that the Insurance company profit margins should be the template for provider profit margins when looking at pricing?

Profits should not be unreasonably high in relation to the risk involved. The Bill does not establish this. Affordability is not addressed in this Bill because it does not address rate reduction and how much more affordable it would be and how many more people it would include.

Keep in mind that Insurance companies do not provide care, they fund care. That funding has established excellent trauma centers around the state with state-of-the art Emergency rooms, imaging equipment, surgical suites, ICU's and rehabilitation programs that may be inpatient, outpatient or residential. The ERs are open 24/7, 365 days per year and the bricks and mortar and capital expenditures are the responsibility of the hospital systems and not the insurance

companies. They take care not only of the automobile accident patients but all trauma patients regardless of cause.

At this time, when Michigan is still poor on a relative basis, as 2010 Census data shows (article attached), this concept of keeping these expenses in the private sector could not be more important.

Between 2009 – 2010 Michigan residents sustained a 1.4% drop in median household income. More Michigan residents are living in poverty. Michigan is last in the nation with a rate of in-migration. Specifically, people moving into the state at an average of 1.2% in 2010 compared to the national average of 2.2%. This, of course, is tied in with employment. Job opportunities are not here. The proposed changes of this Bill will only exacerbate this problem.

The poverty rate has increased to 16.8% in Michigan and 37.8% in Detroit. The national average is 15.3%.

Michigan residents with some form of health insurance coverage currently, is at 87.6%. Those with private insurance have dropped to 68.6%, while public health insurance coverage has increased to 33.2%. In Detroit 39% have insurance – driven by a decline in private health insurance coverage from 42.8% to 39.1%. This implies that public assistance will need to keep increasing. Vocational services through agencies such as Michigan Works! will need to have increased budgets.

The MCCA was initiated in 1978. The current rate of $186 per vehicle is decreasing to $150 on July 1, 2015 and is an outstanding value for the peace of mind and the services it provides. Any time a driver gets into a vehicle alone or with multiple people, they have the peace of mind that if there is an accident, whether they are at fault or not, their expenses will be covered as a lifetime benefit.

In April 2013, it was noted that not as many people are signing up for long-term care insurance because of the expense. Yet, if a mother is driving 3 kids to school each day, then on those days, the car is insured for a dollar a day of disability insurance or 25 cents a person. There is nothing more cost-effective in this country.

The development of technology to help the disabled has become more mainstream and expected. It still requires training by therapists and technological experts to trouble shoot problems, put in controls, clean up viruses, etc.

The whole point of rehabilitation is functional recovery and prevention of medical complications that can hinder it. A person may feel that a person is recovered when the surgical wound is healed, but we still have to give them their life back after that.

Currently drivers cannot sue for medical expenses because they are reimbursable. When that is no longer the case, they will have no recourse but to file a lawsuit. Auto insurance "seems" less expensive in other states on the surface, but when lawsuits are resolved, then they may be spending just as much but it is recorded differently. In those states, patients may wait years for the suit to be resolved and for them to start their treatment.

I can attest to you that very few doctors actively participate with Michigan no-fault insurance at the current time. The demands of documentation and paperwork are extensive for the current level of reimbursement. Rehabilitation physicians at Beaumont Hospital in Royal Oak have chosen over the last several years to no longer see accident victims with no-fault insurance. I can only imagine how difficult it will be to have injured patients gain access to services after the acute phase.

Historically,for example, Workers Compensation was developed without fee screens. The fee screens were added subsequently. They were developed to protect the manufacturing industry in the State of Michigan. At the time they were implemented, there was a risk of manufacturing companies relocating to states such as Indiana, Tennessee, Alabama, and Texas, as well as to Mexico. . The fee screens were put in place to save the manufacturing companies money and to protect jobs. It was not taxpayer funded, as the film industry credits have been. It was funded by hospital systems and healthcare workers as a "loss leader" to attract and maintain manufacturing business.
The manufacturing base in Michigan eroded, regardless. Workers Comp injuries are primarily musculoskeletal or exposure injuries. They generally recover in a shorter time and only rarely are lifelong. Automobile accidents relatively much more catastrophic and, of course, in comparsion to workers can impact children and leave them with life-long disabilities.

The No-Fault insurance business has nothing in common with the manufacturing business. It is not a case of attempting to attract or maintain business in Michigan. The Auto No-Fault insurance business is thriving in Michigan, as attested to by the current profit levels. The MCCA is allegedly robust, with $17-20 billion in reserves.

A traumatic brain injury is an alteration in "brain-behavior" relationships. Thus, it may impact a person physically, cognitively, emotionally, and behaviorally. Thus, we can anticipate increased expenses with Community Mental Health; the Judicial System as more of these patients are unsupervised, do something impulsive and become arrested; the Corrections System as more become incarcerated; the Educational System as students need more support that they cannot get privately; and the Vocational Rehabilitation system, as most will have long exhausted their benefits by the time they are capable of being considered for vocational rehabilitation or work reintegration. Guardians do not want to have legal responsibility for active TBI patients on the streets with no funding. They do not fit into AFC homes and end up with legal problems.

All of these will increase the tax burden on the citizens of Michigan if the current post-acute system of care goes bankrupt related to inadequate reimbursement.

Additionally, according to the Citizens Insurance form several large employers have health plans that do not provide primary coverage for injuries resulting from motor vehicle accidents. These include federal employees such as postal workers or military employees. The following large employers also have exclusions: Wal-Mart, Target, Meijer, Dow, and Nissan. The following hospital groups also have exclusions in their private healthcare policies, including

Beaumont, Allegiance in Jackson, St. John's Providence, Trinity, Sparrow, Port Huron, and McLaren.

Even when individuals have private insurance, there may be significant limitations in coverage that would have a negative impact on individuals injured in motor vehicle accidents. Specifically, Blue Cross/Blue Shield and Blue Care Network do not provide outpatient coverage for cognitive therapy. Most private health plans offer a total of 60 visits per year of occupational therapy, physical therapy, and speech therapy. This is grossly insufficient to meet the needs of these catastrophically injured individuals who may need therapies for several years. Most plans have limited mental health coverage. They have limits on durable medical equipment. They do not provide for home modifications to make a home accessible for a paralyzed individual. They do not provide for vans or van modifications similarly. They may provide no coverage for high-tech prosthetics or orthotics.

There are significant adverse "unintended consequences" from the proposed legislation that will impact the state. When looking at the impact of this Bill and the proposed fee screens, this will have a significant impact on the finances of healthcare systems, particularly those with trauma centers. Nick Vitale, CFO for the 3 hospital Beaumont system, noted in March 2011 that the Beaumont system could lose up to $25 million in the first year. You can multiply this by the DMC, Henry Ford Hospital, St. John Providence, Trinity, Oakwood, University of Michigan, McLaren, Spectrum, etc.

For example, Mr. Vitale noted that "in real life, Beaumont loses money on Worker's compensation claims because reimbursement is below costs."

It is clear that under such circumstances the impact would be the cutting of services and cutting of staff. This would lead to more errors and decreased satisfaction.

There would be the strong likelihood of the cutting of Trauma Programs that benefit all the citizens of a community, not just those injured in motor vehicle accidents. Less profits means less money for capital expenses and capital equipment. There is a possibility of a drain of physicians from the state under those circumstances.

The Michigan Orthopaedic Society said imposing a fee schedule on top of low reimbursement rates by Blue Cross Blue Shield of Michigan could worsen the shortage of surgeons in the state and not "allow patients to return to pre-injury function."

As an example, Oakland County has at least 7 of the large healthcare systems represented within the county. The impact would be enormous. This would also have an impact on the new Oakland University Medical School, which Oakland County executive, Brooks Patterson, was previously quoted as saying would bring $3.2 billion into Oakland County over the next several years.

The only way to make up this shortfall will be to increase the cost of private health insurance.

Previously I spoke with one of the largest Blue/Cross Blue Shield managing agencies in the state. I learned that there was no question that this would drive costs up. He noted that as the risk goes up the cost goes up.

When there are increased benefit costs, they have to be shifted. Employers will sustain some of the costs, but it will shift a portion onto employees. Additionally, this will have a negative impact

on providing raises. Individuals will have less discretionary income. Companies will limit their hiring. They will raise prices, which will be inflationary.

In October 2011, Lynn Weimeister, Director of Government and Community Relations at Beaumont Health System wrote, "In fact, if Workers Compensation rates replace the current rates with automobile insurers, Beaumont would receive $26 million less than our current compensation for both inpatient and outpatient care." There will be cost-shifting to employers. Beaumont, like other employers who are covered by ERISA health plans, would see an increase In their employee health care costs-costs that are now covered by the employee's own automobile insurance programs and the nominal MCCA assessment for lifetime medical care. Since the Bill does not guarantee any reduction in automobile insurance premiums for individuals, it is likely the employees will incur higher health care costs than they do now.

Therefore, we will saddle residents within the State of Michigan to higher taxes, as well as higher benefit expenses with limited hope for increased wages.

One can only imagine how any company considering relocating to Michigan will respond to this inappropriate attempt to move expenses from the private sector to the public sector.

There have been discussions that there needs to be no-fault reform because premiums are unaffordable for some. Specifically, premiums are unaffordable in Detroit.

Unfortunately, unless there is a significant slashing of premiums, it is not going to become affordable. As you may know, hospitals accept all patients through the ER regardless of ability to pay. It is one of the reasons that profit margins are low. Perhaps, Insurance companies could still provide full benefits but have reduced rates for those at low income or poverty levels as proven by their 1040 tax returns or other data. This would be similar to hospitals in providing that type of care. It would be based on income not only on location. Maybe take availability of public transportation into account. Not everyone can afford to own a car.

Of course, in assessing affordability the onus can't just be on the cost of PIP benefits but also on comprehensive and collision benefits. That may be a strong contributing factor.
A further analysis of employment and income may suggest a need to comprehensively increase public transportation as well.

40% of people in Detroit may not have auto insurance. 40% of people in Detroit are also currently unemployed. 37.8% are residing at the poverty level. Thus, it would be unaffordable at any rate.

The state cannot sustain further loss of jobs. Globally I spoke about the impact on the healthcare industry in Michigan. Looking at the Rehabilitation industry as a subset of this, there is the potential for loss of 5,000 jobs and $200 million. These jobs provide the major support in many communities. Not only do they provide direct healthcare services, but also support pharmacies, durable medical equipment suppliers, contractors, accountants, attorneys, and public relations professionals. The loss of up to $200 million dollars of corporate revenue translates to approximately $72 million dollars of reduced payroll taxes to Michigan. As facilities close there will also be the loss of property taxes which will but more pressure on Education.

The expertise developed for traumatic brain injury rehabilitation in the State of Michigan is recognized nationally. Previously, the United States Government awarded 4 of 22 national contracts for support of treating veterans to facilities within the state of Michigan.

There is a saying in rehabilitation that we all learn during our residency. Specifically, *"it is expensive to do rehabilitation the right way, but a lot more expensive to do it the wrong way."* It is difficult to overcome complications or delay or deprive a person the opportunity to become a taxpayer once again.

Senate Bill 248 proposes to fix a system that is not broken. It currently provides the best coverage in the nation, with premiums only 5% higher than the national average. It is a system for drivers and their passengers paid for only by drivers and not by taxpayers. Other states without no-fault insurance have higher tax burdens, as described above. Insurance companies in other states may pay out less in actual claims but once litigation against them is completed, often they are paying out just as much or more. It would be practical to look at net profits of Michigan auto insurers vs. other states.

In recent years the liability portion of the expense for PIP medical benefits is 16th in the nation at $493.56. The average is $471.09. Thus, it is really only $22.47 more than the national average. The collision expense alone is 30% higher than the national average. Contrast this to the 5% for PIP, and it is difficult to understand why the reform is on the PIP side and not on the collision side. Even with the combined expense of PIP along with Comprehensive and Collision, Michigan drivers pay only the 8th highest fees in the nation but clearly they have tax saving and private health care savings since these expenses are covered in the private sector.

Allstate Insurance published a study in 2011 noting that the accident rate in Detroit was 12.5% higher than the national average. Thus, it is not surprising that costs are higher. There
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are issues, reportedly, that relate to fraud regarding Comprehensive and Collision. These need to be dealt with directly. Such abuse impacts the state.

As a concerned citizen, I am concerned about increased taxes, increased health benefit costs, Increased costs for No-Fault insurance at safe levels of coverage, decreased services for injured auto victims, decreased services available from health care institutions and the health status of our communities.

A traumatic brain injured patient may have a brain injury, crushed face, require mechanical ventilation, tracheostomy, and feeding tube, as well as dealing with paralysis, cognitive and behavioral deficits. This will impact them for a lifetime.

Attendant care benefits are being limited. We must keep in mind that maintaining a patient at home is not easy. Homes are not hospitals or facilities. There is no back up. No doctor, specialist or nurse on call. The attendant has to be able to evaluate and make treatment

decisions. Including deciding to go to the ER. The home has a limited formulary of meds, supplies and diagnostic equipment.

It is inappropriate to put in knee-jerk legislation such as payment of $15 per hour regardless of the level of care. There is no other industry that pays on such a wage scale. You can't legislate a one-size fits all level of care. But you are attempting to by such a wage scale. The level of care is determined by the physician prescription for care. A non-nurse can do basic care or be trained to do high-tech care. An RN could decide to do those levels of care and be paid for those levels of care. However, if the prescription is written for RN or LPN level of care, then an RN doing that level of care should be paid as an RN.

You can't put a limit on someone's license or interfere with their contractual employment. Why can an RN work for an agency on a similar client who is not a relative but not work as an RN for a family member?

These attendants may be responsible for meds, wounds, splints, catheterization, bowel programs, behavior management, therapy programs, trouble-shooting equipment issues, communicating to doctors, providers, insurance companies, providing documentation to all of them, etc.

Some patients will simply require more than 24 hour care per day. This means part of the day they will need more than one caregiver at a time. Some patients are totally paralyzed or have limited mobility with severe spasticity. One person may not be able to move them at all or to move them safely. The patient could be dropped or the caregiver could be hurt.

St. Joseph Mercy Health System HR Policy #780 is "Safe Lifting and Handling Techniques." Included in the policy is the following language:
If, when engaged in lifting, employees must lift or bear 48 pounds or more of the patient's weight, they must use a lifting device or get assistance while lifting.

When lifting greater than 48 pounds, employees are <u>required</u> to use assistive devices. The team approach also requires that more than one employee assist in the transfer.
These patients can be dead weight. An agency would never accept a home care case that did not allow them to treat the patient and their employees safely. Why would we discriminate against patients who chose family provided home care?

There are other examples of the need to have more than one care giver at time including when attempting to do therapy on a mat where one of the caregivers has to hold a patient up or stabilize a neck, etc. When suctioning might be done. Where there is extreme agitation.
Where someone needs to hold legs apart to do personal care, catheterization or a bowel program, etc.

I understand that a Medical Review can be requested for approval for a second caregiver.
Why not simply follow the prescription of the doctor who is trained to assess this and can determine the need? Why increase costs by bringing in another physician?
How will the review be requested?
Who will do it?
How long will it take?
What is the appeals process?
What happens to the patient's care while they are waiting?

Again, why not leave the responsibility to the prescribing physician who will document the medical necessity anyway?

There was also a proposal to reimburse only for semi-private rooms unless the patient was in a specialty unit or ICU. For about the last 30 years, almost all new hospital construction or renovation has done away with semi-private rooms so it is inappropriate to put in that language and saddle someone going through this tragedy with bills for private rooms when that is all that might be available to them.

There is no confirmed cost savings with the reduced benefits. In the same Crain's article, Ari Adler, press secretary for then Republican House Speaker, Jase Bolger, said no-fault auto reform legislation would be introduced. He said " the insurance industry wants it done." That is not a sufficient reason particularly without their honest collaboration in solving any perceived problems.

The proposed legislation offers no benefits for injured drivers or their families. It only limits benefits. It provides only burdens for the healthcare system, already poorly-funded state agencies, and increased taxes for residents of the state of Michigan.

This legislation does not pass "The Compass for Responsible Government." It will make it more difficult for us to create more and better jobs. It increases the price of government. It increases the cost of living. It increases the cost of doing business. It does not seek to secure our rights to life, liberty, and the pursuit of happiness.

Thank you for the opportunity of sharing my thoughts with you. I am available to discuss these issues with you at any time that is convenient for you.

Respectfully yours,

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Stage set for 'battle royal' between auto insurers and providers over cutting reimbursement under Michigan's expansive no-fault auto law

By Jay Greene

I haven't been to a good old fashioned "battle royal" legislative committee hearing in Michigan for a while.

The last contentious hearings I attended, held in early 2008, were ones that Tom George, M.D., the Kalamazoo anesthesiologist and former chairman of the Senate Health Care Committee, conducted on Blue Cross' effort to "reform" the individual health insurance market.

Blue Cross, the insurer, lost that battle royal. The individual health insurance market is still a mess, although health care reform and the insurance exchanges will most likely to help Blue Cross cut their losses in the individual market starting in 2014.

That is another story that I may blog about soon.

Now we are in the 2011 Michigan legislative season and we have a new insurance battle brewing, this time over medical fee schedules for hospitals, doctors and other providers that submit auto insurance claims.

I wrote a news story about this in Crain's Detroit Business this week. Click here to read it.

Of course, the Michigan state budget deficit and related issues take front and center and that debate may drain the swamp of other serious debates.

But it is almost certain that the bill (Senate Bill 294) introduced last week by Sen. Joe Hune, R-Hamburg Township, to set a medical fee schedule will be heatedly debated.

A medical fee schedule is very upsetting to hospitals, physicians, physical therapists and other health providers because it would drastically cut their payments, among other things.

The Insurance Institute of Michigan is preparing a lobbying campaign to restate their case that the state's no-fault auto laws, which offers unlimited medical coverage, should be modified.

But for whose benefit? Critics say insurers are simply trying to reduce their claim expenses. Insurers say they are trying to reduce premiums by giving people who purchase auto insurance choices.

One point is clear: Reforming Michigan's no-fault auto law, which went into effect in 1973, has been on the agenda of auto insurers for many years.

The Coalition for Protecting No-Fault Auto - formed in 2006 by the hospital, physician, nursing, trial lawyers, consumer and labor union lobbies – has successfully beat back similar legislation.

The Coalition may not succeed this year because both state houses and the governor's office are controlled by Republicans. Democrats in previous years held the insurance industry at bay in previous years. If you haven't noticed, Republicans are all about cutting costs these days.

It is important to note that Michigan voters took up the issue of medical fee schedules back in 1992 and 1994. Voters rejected Proposal D and Proposal C.

Under current law, insurers cannot use fee schedules to pay claims, although they often refuse to pay the full amount of a doctor's or hospital's bill.

Stacie Saylor, reimbursement manager for the Michigan State Medical Society, said auto insurers regularly reject physician bills for their treatment.

"Doctors have to resubmit or appeal denials all the time," she said. "Insurers hope to delay payments or pay lower amounts."

The Insurance Institute contends a medical fee schedule – similar to that used in workers' compensation since the mid-1980s – could lower auto premiums by 10 percent to 30 percent, depending on coverage levels, according to a 2007 study for the institute by Epic Consulting, Carlock, Ill.

But if a medical fee schedule were used to pay auto accident claims, hospitals, physicians, nursing homes and other providers could stand to lose millions of dollars in reimbursements.

"A reduction in payment for services rendered would be significant and in excess of $25 million on an annual basis," said Nick Vitale, senior vice president of financial operations at three-hospital William Beaumont Hospitals in Royal Oak.

"The bill portrays to save money for those insured, but it reduces the level of benefits," said Vitale, adding: "If somebody gets really injured and can't work, somebody has to pay for the claims. There could be huge out-of-pocket expenses for health care."

In a statement to Crain's, the Michigan Orthopaedic Society said imposing a fee schedule on top of low reimbursement rates by Blue Cross Blue Shield of Michigan could worsen the shortage of surgeons in the state and not "allow patients to return to pre-injury function."

But Pete Kuhnmuench, executive director of the Lansing-based Insurance Institute, said a fee schedule and other reforms are needed to check growing provider reimbursement. The state's 38-year-old auto no-fault law contains the nation's only unlimited and lifetime medical benefit provision.

"There has been a stalemate legislatively and all the while medical costs continue to grow," said Kuhnmuench, who said unlimited medical benefits, overbilling and insurance fraud has contributed to rising premiums in Michigan.

Two recent studies indicated that Michigan's auto premium rates are one of the highest in the country.

For example, a recent study by www.insure.com, a consumer website, showed auto rates in Michigan for a 40-year-old man with a clean driving record is $2,541 per year, the highest in the country.

On the other hand, the National Association of Insurance Commissioners said in December that Michigan ranks 11th most expensive with an average premium of $1,032 in 2008.

Kuhnmuench points out that during the past decade medical care costs have risen 51 percent in Michigan, while inflation increased 27 percent. From 1997 to 2007, the average auto insurance medical claim rose more than 225 percent, said the study.

Laura Appel, vice president for federal policy and advocacy with the Michigan Health and Hospital Association, makes a good point when she says that auto insurers cannot guarantee premiums will go down.

"They have been asked in hearings about the 20 percent premium reduction and never promised rates would go down," Appel said. "They said the average would go down."

Kuhnmuench points out that auto insurers can't collectively promise to lower premiums because that would be "collusion" and could spark the imagination of government antitrust lawyers.

"Competition will work in Michigan to lower premiums," he said.

Appel counters that another one of the problems with medical fee schedules is that some hospitals, especially trauma centers and sole-provider hospitals, could receive

higher numbers of accident victims than others and be disproportionately affected by the lower reimbursements.

"Fee schedules are determined by understanding with relative certainty the different volumes and services you will be providing," Appel said. "But there is no predictability with auto accidents."

Kuhnmuench responds by saying the same could be said about workers' compensation claims - who knows when a worker will be injured on the job?

"The workers' compensation fee schedule is a real quiet success," Kuhnmuench said. "There is a fee schedule for each procedure. They are adjusted on a rotating basis every year, adding and deleting procedures."

But Vitale explains that, in real life, Beaumont loses money on workers' compensation claims because reimbursement is below costs.

Adding a medical fee schedule would further cut into slim hospital profit margins, he said.

The Michigan Health and Hospital Association say that average hospital profit margins on patient care services are below zero. Nationally, hospital profit margins are about 5 percent.

"We are very concerned and very opposed to the bill," Vitale said. "It would hurt the health care system, the patient population and those insured."

Looking on the positive side, Saylor said a fee schedule could give physicians greater certainty that insurers would pay their bills. On the negative, she said doctors would still receive lower reimbursements.

"Right now insurers pay reasonable and customary charges that are always less than what physicians charge," Saylor said.

Ari Adler, press secretary for Republican House Speaker James "Jase" Bolger, R-Marshall, said no-fault auto reform legislation will be introduced. The bills will be similar to House Bills 6094 and 6095 that were introduced last year.

"The insurance industry wants it done," Adler said. "There is a significant difference in paid charges to providers compared with other types of insurance – Medicare, Medicaid and Blue Cross."

Besides the medical fee schedule, Kuhnmuench said two other key provisions are included in bills to give consumers choice and help drive down auto premiums.

MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

FOR IMMEDIATE RELEASE
November 8, 2011

Contact: Ruthanne Sudderth
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Proposed Changes to Auto No-fault Law Slash Hospital Patient Care Resources

Local Hospitals Will Lose Tens of Millions of Dollars for Patient Care, Trauma Units

DETROIT — Health care providers in Southeast Michigan are urging lawmakers to put a halt to dangerous legislation that puts accident victims, jobs and taxpayer money at risk, and instead protect the state's auto no-fault insurance law. Should the Legislature fail to do so, area hospitals and health systems including **Beaumont Health System**, Royal Oak; **Detroit Medical Center**; **Henry Ford Health System**, Detroit; Mount **Clemens Regional Medical Center; Oakwood Healthcare Inc.**, Dearborn; **Saint Joseph Mercy Health System**, Ann Arbor; and **St. John Providence Health System**, Warren, will lose tens of millions of dollars that fund patient care and trauma units.

The Michigan Legislature is considering House Bill (HB) 4936, legislation that would eliminate the lifetime medical care currently afforded through auto no-fault coverage, which has governed health insurance coverage for catastrophic automobile accidents since 1973. The proposals would allow auto insurers to choose the amount of personal injury protection (PIP) coverage they offer to drivers, ranging from as little as $500,000 to a maximum of $5 million. However, it would be impossible for any driver to choose unlimited PIP insurance, and a driver whose injury costs exceed the amount of purchased coverage would be forced to bring a lawsuit against another driver or, after exhausting personal resources, be forced onto the taxpayer-funded Medicaid program. Similar legislation has been introduced in the Senate, but has not yet seen action.

Under the bills, payment to health care providers treating and rehabilitating those injured in traumatic automobile accidents would be regulated by both the amount of insurance carried by the victims and a provision requiring that reimbursement be made under Michigan's Workers' Compensation fee schedule. This schedule is a governmentally determined price regulation on the amount of reimbursement providers can receive for treating injuries, regardless of the severity or the intensity of treatment necessary. The schedule, which was never designed or intended to address the extensive needs of those catastrophically injured in auto accidents, would apply to all health services provided, including those by hospitals, physicians, rehabilitation programs and long-term-care facilities.

Southeast Michigan hospitals and health systems would experience massive losses as a result of imposing the Workers' Compensation fee schedule on the care of auto accident victims. Should the proposal become law, current service levels would be cut and trauma units that care for those with catastrophic injuries would be jeopardized. Ultimately, these changes would cost jobs and threaten health care access for every Michigan resident.

-OVER-

Hospital/Health System	Annual Loss
Beaumont Health System, Royal Oak	$ 26 million
Detroit Medical Center	$ 24 million
Henry Ford Health System, Detroit	$ 9.5 million
Mount Clemens Regional Medical Center	$ 3.7 million
Oakwood Healthcare, Dearborn	$ 18.3 million
Saint Joseph Mercy Health System, Ann Arbor	$ 12.7 million
St. John Providence Health System, Warren	$ 9.3 million

Despite the certain loss of health care benefits to accident victims and resources for patient care, the legislation provides no discernable value or improvement for consumers. The bill does not require auto insurers to, in turn, reduce subscriber premiums as a result of the diminished health care coverage. **In fact, insurers have openly acknowledged that they will not commit to lowering premiums.**

Michigan's health care community asks the Legislature to defend the state's auto no-fault law, which citizens have already voted to protect twice, by voting "no" on HB 4936. Preventing these irresponsible changes will help protect Michigan drivers, accident victims and families and preserve access to critically needed health care for everyone.

For more information, visit the Michigan Health & Hospital Association (MHA) online at www.mha.org or follow the Coalition Protecting Auto No-Fault on Facebook and Twitter (@ProtectNoFault).

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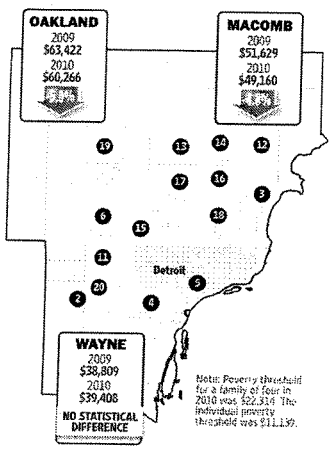
Income, poverty and health insurance coverage

Michigan households brought in less income last year than they did in 2009, and poverty rates have increased, new American Community Survey data released today show. Michigan residents are insured at a higher rate than the U.S. population, remaining statistically unchanged between 2009 and 2010.

MEDIAN INCOME CHANGES	WITH HEALTH INSURANCE COVERAGE	% PEOPLE BELOW THE POVERTY LEVEL	% CHILDREN LIVING BELOW THE POVERTY LEVEL
U.S.			
2009 $51,190	2009 84.9%	2009 14.3%	2009 20.0%
2010 $50,046	2010 84.5%	2010 15.3%	2010 21.6%
-2.2%	-0.4	+1.0	+1.6
Michigan			
2009 $46,078	2009 87.8%	2009 16.2%	2009 22.5%
2010 $45,413	2010 87.6%	2010 16.8%	2010 23.5%
-1.4%	NO STATISTICAL DIFFERENCE	+0.6	+1.0



Source: U.S. Census Bureau, American Community Survey

COMMUNITIES WITH A POPULATION GREATER THAN 65,000	MEDIAN INCOME CHANGES 2009	2010	% change	WITH HEALTH INSURANCE COVERAGE 2009	2010	% PEOPLE BELOW THE POVERTY LEVEL 2009	2010	% CHILDREN (UNDER 18) LIVING BELOW THE POVERTY LEVEL 2009	2010
1 Ann Arbor	$51,033	$52,711	3.3%	94.3%	94.0%	20.6%	19.9%	9.2%	14.8%
2 Canton	82,644	71,148	-13.9%	89.7%	90.8%	5.5%	7.6%	6.1%	12.3%
3 Clinton Township	47,413	44,527	-6.1%	87.6%	87.0%	8.8%	11.2%	9.1%	14.9%
4 Dearborn	45,619	43,505	-4.6%	84.5%	85.3%	22.3%	28.6%	37.6%	40.9%
5 Detroit	26,599	25,787	-3.1%	81.6%	79.9%	36.4%	37.6%	50.8%	53.6%
6 Farmington Hills	68,576	60,562	-11.7%	91.9%	92.2%	7.4%	7.4%	9.5%	9.0%
7 Flint	27,426	22,672	-17.3%	87.4%	86.9%	36.2%	41.2%	52.8%	63.1%
8 Grand Rapids	38,361	36,128	-5.8%	83.7%	86.0%	24.1%	30.0%	37.2%	43.7%
9 Kalamazoo	27,393	31,421	14.7%	82.8%	88.0%	35.6%	38.8%	44.7%	53.3%
10 Lansing	36,546	34,770	-4.9%	85.4%	87.2%	23.8%	26.9%	35.1%	37.9%
11 Livonia	67,655	65,391	-3.3%	91.3%	91.3%	6.8%	7.8%	7.0%	15.6%
12 Macomb Township	81,777	81,563	-0.3%	93.2%	92.5%	5.3%	6.4%	7.7%	8.8%
13 Rochester Hills	72,277	68,386	-5.4%	89.5%	91.7%	7.8%	8.2%	10.9%	11.8%
14 Shelby Township	62,721	56,276	-10.3%	88.5%	90.5%	10.2%	10.0%	16.8%	11.2%
15 Southfield	50,284	47,197	-6.1%	90.7%	87.6%	16.0%	13.3%	22.9%	16.3%
16 Sterling Heights	52,337	53,390	2.0%	87.9%	85.9%	12.2%	12.8%	16.7%	16.4%
17 Troy	87,027	77,827	-10.6%	93.2%	92.2%	6.7%	4.9%	8.8%	4.5%
18 Warren	44,337	41,587	-6.2%	84.7%	85.6%	13.8%	20.5%	20.7%	32.0%
19 Waterford	51,225	57,949	13.1%	88.1%	87.3%	15.5%	8.3%	29.4%	11.1%
20 Westland	44,626	39,657	-11.1%	84.2%	84.1%	18.9%	17.6%	27.3%	27.8%
21 Wyoming	41,981	40,454	-3.6%	86.5%	81.5%	17.3%	21.3%	27.1%	33.0%

*Notes whether the estimates between years aren't statistically different from each other at a 90% confidence level. The survey is completed annually and is based on a sample of about 3 million U.S. households

DAVID PIERCE/Detroit Free Press

Safe Lifting and Handling Techniques - Patients

Section Number 700 - Employee Health
Policy Number 780

Effective Date: 05/01/97
Revised Date: 10/13/99, 01/27/05, 7/6/06, 4/6/09
Reviewed Date: 7/1/08

Approved by: Garry C. Faja, President and CEO

Purpose

It is the policy of St. Joseph Mercy Hospital (SJMHS) to provide a safe working environment in which patient safety, employee safety, and overall injury prevention is a major focus. Proper training and education of employees will help decrease employee work-related injuries, provide optimum patient care and promote patient comfort and mobility.

1. All employees will use appropriate assistive devices in all circumstances when lifting or handling patients.
2. A patient fall is an event that has a high risk of injury for both the patient and employee. Under no circumstances should an employee lift a falling patient into bed or into a chair. A medical emergency may require additional assessment to determine how best to assist the patient.

Roles and Responsibilities

1. All employees who are required to lift and handle patients as part of their job responsibilities will:
   a. Receive training upon hire, and as necessary thereafter, in body mechanics, patient lifting techniques and use of lifting and other assistive devices.
   b. Demonstrate competencies associated with proper body mechanics, patient lifting techniques and use of lifting and other assistive devices.
2. All managers who supervise employees required to lift and handle patients will:
   a. Require that employees have the proper lifting and other assistive equipment instruction and competency testing necessary to keep employees ready to practice safe patient lifting and handling.
   b. Counsel and progressively discipline employees who do not follow the safe lift and handling guidelines set forth in this policy.

Procedure

A. Patient Assessment

1. Upon entry into the facility, and on an on-going basis, patient mobility needs are assessed. Areas to be assessed include cognitive and physical abilities.
2. An evaluation of the types of lifting or other assistive devices, and the amount of assistance required for the patient will be determined and communicated through the nursing report and/or the patient's medical record.
3. Assessment is necessary to determine the needs of the patient in all transfers. Clinical judgment must be used when deciding where, how, and under what circumstances assistive devices are required for patient lifting and handling.

B. Transfer Devices/Techniques - See Appendix A

1. Gait Belts
   a. Gait belts are used when ambulating patients who require assistance.
   b. Gait belts may be used for patients requiring stand by assistance.
2. Patient Lifting Devices
   When patients cannot independently lift or move themselves, staff will use a lift device, or work with a sufficient number of other staff, to assure both patient and staff safety during lifting and handling. If, when engaged in lifting, employees must lift or bear 48 lbs. or more of the patient's weight, they must use a lifting device or get assistance

while lifting. Typically, this would include patients unable to assist in a transfer, or patients that cannot bear weight bilaterally. A mechanical lift must be used ANYTIME the staff determine that this is the safest way to transfer the patient considering the employee safety, and patient safety and comfort. For patients weighing more than 450 lbs., contact the Patient Resource Manager for appropriate bed placement.

a. Lifts must be in a designated location in the clinical area/work area and must be returned to this area after use.
b. Requirements for maintaining cleanliness of slings, harnesses, and other assistive devices:
   i. Use a sheet over the sling any time you are lifting a patient to prevent skin to sling superficial contamination.
   ii. Protect draining wounds with an absorbent pad.
   iii. Patients with multi-drug resistant pathogens must have their own sling designated for them to use, which must be properly cleaned upon discharge of that patient.
   iv. Establish a routine cleaning schedule of all slings; i.e., once every week or when visibly soiled, with a monitor to assure compliance. May use any health system approved surface cleaning agent to wipe off slings, harnesses, and mattresses between uses, or usage, and patients.

3. Slideboards and slip sheets are to be used for partial and stand-by assists, and dependent patient transfers as indicated.

4. Draw Sheets - Draw sheets may be used when turning patients in bed. However, a draw sheet is NOT an appropriate transfer or lifting device.

5. Team Approach - When lifting greater than 48 pounds, employees are required to use assistive devices. The team approach also requires that ~~more than one~~ employee assist in the transfer.

6. Additional Safety Considerations
   a. Wheel locks on beds are kept in a locked position except when moving the bed. Prior to moving a patient in bed or transferring a patient to or from bed, wheel locks must be checked to insure that they are in the locked position. Any defective brakes must be reported and repaired.
   b. A trapeze should be considered for those patients who can benefit from its use, and for those who have amputations or limited use of their lower extremities. When the patient is capable, the use of the trapeze is encouraged.
   c. The height of the bed should be adjusted to enable employees to use leg muscles when transferring, turning, boosting patients, changing bed linens, and/or implementing clinical procedures.
   d. Although wheelchairs and stretchers are designed to be pushed by one person using proper body mechanics, staff may require additional assistance based on patient size, weight and/or condition.
   e. Patient beds are not designed for patient transportation. If a patient is clinically required to be transported in their bed, at least two employees must be involved in the transportation of that patient.

7. Resources - Physical Medicine and Rehabilitation Services is available by physician order to problem solve difficult patient handling situations.

See APPENDIX A – SJMH Safe Patient Lifting & Handling Decision Matrix

See APPENDIX B – Standard Operating Procedure for safe patient lifting and handling.